DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced, bi-annual and complaint survey was conducted at this facility from July 24, 2012 through August 1, 2012. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and seventy-five (175). The survey sample totaled thirty-eight (38) residents.	F 000	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 09/30/12.9	9/30/12
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 A. R270 has had no further complaints regarding "rough treatment" and was satisfied with the investigation and outcome of the incident identified during survey. B. An audit was conducted on alleged abuse from date of survey exit to present to ensure timely reporting to the state. Any issues identified for timely reporting of alleged abuse was reported to the state immediately and an investigation was conducted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/21/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview it was determined that for one (R270) out of 38 sampled residents the facility failed to identify an allegation of abuse resulting in the failure to immediately report the allegation to the state agency. Findings include: Review of the facility Resident / Family Grievance Report dated 7/19/12 documented that R270 told facility staff that an aide was rough during care and snapped her elastic waist band. The facility investigated the concern, relocated the aide off R270's assignment, and provided additional training to the aide. The resident was satisfied with the results. The facility however failed to identify the concern as an allegation of abuse and failed to immediately report it to the state agency. An interview on 7/30/12 with E2 (DON) confirmed that the allegation of abuse was not identified and not reported to the state agency until 7/27/12	F 225	C. Nursing management and department heads received education on process for reporting alleged abuse to the state and contacting the Administrator and/or DON/ADON promptly of alleged abuse incidents. D. Alleged abuse incidents are reviewed M-F in the AM meeting and information regarding alleged abuse is reported at the monthly QA/QI meeting by the ADON or designee, to ensure all allegations have been reported in a timely manner through the state reporting process	

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F 225	Continued From page 2 when the surveyor asked for the incident report. E2 further revealed that the incident was thoroughly investigated but staff failed to identify the incident as an allegation of abuse therefore it did not get reported to the state agency.	F 225	F241 A. R207 and R19 both still reside at the facility and are receiving their meals at the same time when dining together in their room or seated at the same table. R208 and R174 are no longer served by staff using a glove. B. An initial audit was conducted at meal pass times to identify how trays are delivered to residents to assure tray delivery is provided to residents during the same timeframe when residents are in their room or seated at the same table. Meal carts were rearranged accordingly. An initial audit was conducted at meal pass times to identify if staff wears gloves while assisting residents with their meals. Any issues identified were corrected immediately. C. Meals carts have been rearranged to accommodate residents eating together. Dietary and nursing staff received education on providing meals to residents during the same timeframe while residents are in	9/30/12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that for three residents (R207, R208 and R174) the facility failed to provide care in a manner that enhanced the dignity of residents. Findings include: 1. During lunch observation on 7/24/12 at 12:24 PM R207 was observed in bed and his roommate, R19 was eating lunch. R207 did not receive his lunch tray and assistance with his meal until 12:40 PM. An interview with E13 (CNA) revealed that staff had to get all the trays out before she could set up R207 to feed him. 2. During lunch observation in the Station 3 assisted dining room on 7/24/12 at 12:07 PM, E9 (CNA) placed a glove on his left hand to butter R208's bread. He assisted in feeding R208 with the glove remaining on his hand. 3. E9 was also observed feeding R174 at 12:42 PM with the same glove on his hand. The facility	F 241		

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F 241	Continued From page 3 failed to serve food in a dignified manner to residents. Findings reviewed with E1(Administrator) and E2 (DON) on 8/1/12 at 2:45 PM.	F 241	their room or seated at the same table. Nursing staff received education regarding serving food to residents in a dignified manner. D. A monthly audit is conducted x 3 months to ensure compliance with tray delivery and provided to residents during the same timeframe when residents are in their room or seated at the same table and that meals are served in a dignified manner. Data will be reported at the monthly QI meeting by Food Service Director or designee.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure reasonable accommodations of individual needs. The facility failed to ensure that the call bell for two residents (R207 and R67) was within reach. Findings include: 1. During an initial tour of the facility on 7/24/12 at approximately 10 AM, R207 was observed in his bed with the call bell out of reach on the night stand table. Surveyor interviewed E7 (nurse) immediately after the above observation and confirmed that R207 did use the call bell and that it was out of reach for the resident. The call bell was observed to be out of reach again, this time on the floor behind the headboard at 12:24 PM. The surveyor alerted staff. 2. On 7/24/12 at approximately 2 PM, R67 was	F 246	F246 A. R207 and R67 still reside at the facility and have not had any further occurrence's of their call light not being within reach when in/out of bed. B. An initial audit was conducted on all residents to ensure call lights were within reach. Any issues identified were corrected immediately. C. Ambassador Rounds were reviewed and revised to include more frequent rounding to ensure	9/30/12

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F 246	Continued From page 4 observed sitting in her wheelchair with the call bell wrapped around the grab bar and out of reach of the resident. An interview with E8 (nurse) and E9 (aide) subsequent to the above observation on 7/24/12 at approximately 2:05 PM confirmed that the resident did utilize the call bell and it was out of reach of the resident.	F 246	call lights are within reach of all residents when they are in/out of bed. All staff were re-educated on placement of call bells for residents when they are in/out of bed.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations of the resident rooms on 7/26/12, 7/31/12 and 8/1/12, it was determined that the facility failed to provide maintenance services necessary to maintain a comfortable and orderly interior. Findings include: On 7/31/12 the following was observed: 1. The entrance doors to rooms 119, 306, and 603 had scratches, scrapes, and gouges on the exterior surface making the appearance of the doors unaesthetic. The closet doors of rooms 106 and 410 and had scratches and scrapes making the appearance unaesthetic. The bathroom doors of rooms 410 and 603 had scratches and scrapes on the room-side surfaces. 2. The bedside stand of room 306A had veneer that was worn and scratched. The dresser in this room had a scratched and damaged veneer. The	F 253	D. Ambassador rounds data for call bell placement is aggregated and analyzed monthly x 3 months and reported at monthly QA/QI meeting by QA/QI Nurse or designee. F253 A. Immediate repairs were made to those resident's rooms affected in numbers 106, 119, 122, 306, 410, 603 and 703. B. A house wide audit of resident rooms was made to identify any potential unaesthetic appearance. All identified surfaces needing attention were corrected immediately.	9/30/12

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F 253	Continued From page 5 dresser in room 603 had a marked and scratched veneer as well as 1/2 of the decorative molding surrounding the top broken off. 3. The bathroom walls of rooms 106, 306, and the door jamb of 603 had scuffs and scrapes. on 8-1-12 the following was observed: 4. The window-side bed of room 703 had a trapeze apparatus attached to it that had made several large gouges into the wall behind the headboard. 5. On 7/26/12 and 8/1/12, room 122, the window-side bed, had an electrical outlet missing the cover behind the headboard.	F 253	C. Routine Ambassador Rounds will be used to identify and report surface damages immediately to the maintenance department using the REQQER (internal electronic reporting system for repairs). D. Monthly REQQER reports will be used to monitor frequency of this deficient practice and reported at monthly QA meetings X 3 months.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	F272 A. R226 no longer resides at the facility. A voiding diary was re-initiated on R199, data analyzed and a toileting program was implemented. Care plan was revised to reflect current toileting status. B. An initial audit was conducted on all residents to identify if any of residents were in need of dental services. Any issues identified were addressed immediately.	9/30/12

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F 272	Continued From page 6 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview it was determined that the facility failed to do an accurate assessment for two (R226 and R199) out of 38 sampled residents. Findings include: 1. R226 was admitted to the facility on 7/9/12. The facility performed an admission assessment on R226 that included an oral/nutritional assessment. This assessment indicated R226 had his own teeth with no problems. Therefore, dental services were not offered to R226. On 7/15/12 E6 (RN unit manager) assessed R226's mouth and noted that he was edentulous besides broken carious teeth. E6 stated that	F 272	An initial audit was conducted on all residents to re-assess completion of voiding diaries and implementation of toileting programs. Revisions to toileting programs were implemented as appropriate. C. Urinary and Bowel Incontinence policy and procedure, voiding diary and toileting program was reviewed. Licensed nurses were re-educated on the Urinary and Bowel Incontinence policy and procedure, process for completing voiding diaries and analyzing data to implement a toileting program. Licensed nurses received education on dental assessment, documentation on admission assessment of dental status and dental section of MDS. New admissions and re-admissions are reviewed at the routine AM meeting to identify residents needing voiding diaries initiated and dental services needed.	

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F 272	Continued From page 7 R226's admission assessment and R226's MDS were not accurate therefore, dental services were not offered to R226. 2. Cross refer F315-1 Review of R199's MDS assessment dated 6/2/12 revealed that R199 was severely impaired for cognitive decision making, required extensive assistance of two person physical assist for transfer and toilet use, resident was occasionally incontinent of urine and was not on a trial of a toileting program. Although the facility completed a three day diary which revealed that R199 had three episodes of incontinence on 5/31/12 at 1 PM, 5 AM, and 6 AM, record review lacked evidence that the facility analyzed the collected data to determine trends and to determine the appropriateness of a toileting program. During an interview on 7/30/12 at approximately 10:30 AM with E3, Unit Manager he confirmed that the 3 day voiding diary was initiated but that he failed to analyze the "3-Day Bowel and Bladder Evaluation" form at the completion of the three days. This portion of the assessment is used to assist in determining the appropriateness of a toileting program. Above findings reviewed with E1 (Administrator) and E2 (Director or Nursing) on 8/1/12 at approximately 2:45 PM.	F 272	D.Audit on residents on voiding diaries and toileting programs is conducted by the QA/QI Nurse or designee monthly x 3 months; and repo the monthly QA/QI Meeting. Audits on new admissions and re-admissions is conducted by Social Services x 3 months; and reported at the monthly QA/QI meeting.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 8 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R76) out of 38 sampled residents the facility failed to develop a comprehensive care plan for an identified resident care area. The facility failed to develop a care plan for the targeted behaviors for which R76 was receiving psychoactive medications. Findings include: Cross refer F329, example #1a and #1b. Review of R76's July 2012 Physician's Order Sheet (POS) revealed that R76 was prescribed routine doses of clonazepam (benzodiazepine) 0.25 mg. by mouth every 12 hours as well as Seroquel (anti-psychotic medication) 37.5 mg. by mouth every morning and Seroquel 50 mg. by	F 279	F279 A. R76's care plan and Behavior Modification Form (BMF) reflects target behaviors and non-pharmacological interventions for all psychoactive medications currently prescribed. B. An initial audit was conducted on 8/13/12 and 8/14/12 by the licensed pharmacists on all residents receiving psychoactive medications (excluding anti-depressants) to ensure residents are appropriately monitored for targeted behaviors and appropriate interventions, including non-pharmacological interventions as appropriate. C. BMF was reviewed and revised. Policy and Procedure was developed for reducing or eliminating antipsychotics for residents with behavioral symptoms. Licensed staff and Social Services received education on completion of revised BMF and policy and procedure of reducing or eliminating antipsychotics for residents with behavioral symptoms.	9/30/12

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F 279	Continued From page 9 mouth every night for paranoia and delusions. In addition, Ativan (benzodiazepine) 0.5 mg. by mouth as needed every 4 hours for anxiety was prescribed. Record review lacked evidence of a care plan which identified the targeted behaviors for which R76 was receiving the above psychoactive medications including non-pharmacological interventions personalized to meet the resident needs. Review of R76's July 2012 "Psychoactive Medication Monthly Flow Record (Also known as the BMF-Behavior Modification Record") included the following targeted behaviors were being monitored including delusions, paranoia, disruptive behavior, talking to others not there, however, the non-pharmacological interventions lacked evidence that these were individualized. An interview with E4 (Director of Social Services) on 8/1/12 at approximately 2 PM confirmed that there was no care plan for the targeted behavior symptoms.	F 279	D. Audit on residents receiving psychoactive drugs and completion of BMF is conducted monthly, ongoing, by licensed pharmacists and reported by the QA/QI Nurse at the monthly QA/QI meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 A. Residents R160 and R20 care plans were revised and progress notes added to address the resident's current status. B. A care plan audit was completed on all residents receiving psychoactive drugs. Any issues identified were corrected.	9/30/12

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F 280	Continued From page 10 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to review and revise the care plan for two (R160 and R20) out of 38 sampled residents. Findings include: 1. Review of R160's care plan titled "Alteration in mood state which included verbal expressions of distress, sad, apathetic, anxious appearance or withdrawn dated 12/15/11 included R160 will demonstrate an improved mood as evidenced by getting out of her room and interacting with staff and other residents. Approaches included: - Monitor effectiveness/side effect of medication as ordered. The above care plan included the date of 12/15/11 as the most recent revision date. During the survey on 7/31/12 at approximately 12 noon, the surveyor was provided a copy of the above care plan which stated " care plan reviewed 2/12/12 and 4/12/12. care plan was still appropriate " by E5 (social services). On 7/31/12 at 2 PM, the surveyor interviewed E5 related to	F 280	C. Re-educate licensed staff on the monitoring of behavior of residents receiving psychoactive drugs and the documentation on care plans, assessments and progress notes with periodic reviews and revisions as necessary. D. A random monthly audit of documentation of residents receiving psychoactive medication will be done monthly X 3 months by the QA nurse or designee. Results will be reported at the monthly QI meeting.	

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F 280	Continued From page 11 the new documentation on the above care plan and the surveyor requested evidence that the above care plan was reviewed. Subsequent to this conversation, E5 informed the surveyor on 7/31/12 at 3 PM that there was no progress note which documented whether the goals were met on 2/12/12 and 4/12/12. 2. R20 was readmitted to the facility on 5/8/12. Review of R20's minimum data set assessments (MDS) included 4 unscheduled assessments (for significant change) between 5/27/12 and 7/8/12. Documentation of" verbal behavior symptoms every 1-3 days" were consistently noted and "rejection of care" had increased from every 4-6 days to daily since the 6/24/12 MDS. Nursing assessments and notes from 6/10/12- 7/30/12 supported the MDS documentation. R20's lack of participation and noncompliance behaviors along with refusal for restorative care referral were documented in physical therapy's (PT) discharge summary (service 5/9/12- 7/23/12). R20's care plan titled Behavior Problem contained the goals "resident will have": -fewer episodes of yelling and being verbally abusive (less than 3 times week) -fewer episodes paranoia and refusing medication and care to 2 times per week. Interview on 7/31/12 with E5 (social worker) at 11:00 AM concerning R20's care plan updates	F 280		

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F 280	Continued From page 12 revealed no social service documentation since 5/14/12. No documentation evidence of R20's care plan meeting evaluation on 5/29/12 or revisions/updates to care plan to include goals not met or interventions for these significant changes were found by E5. Review of findings with E11 (corporate nurse) on 7/31/12 at approximately 12 noon, confirmed that the facility failed to review and revise R20's care plan when the behaviors increased.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and review of the facility's policy and procedures, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable level for two (R97 and R63) out of 38 sampled residents. The facility failed to assess and reassess pain for R97 and failed to follow the plan of care for stool collection for R63. Findings include: Review of facility's policy "Pain evaluation and management policy" indicated under "policy statement" it is the policy of this facility to	F 309	F309 A. R97 pain management has been reviewed and no further issues have occurred. R63 was transferred to an acute care facility and there were no orders for a stool collection upon re-admit. B. An audit was conducted of all residents MAR to identify any residents having pain to determine if pain management is being managed effectively. Any resident identified with pain mgt issues, the physician was notified and their pain issues were addressed. An audit was	9/30/12

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F 309	Continued From page 13 evaluate the resident's pain level ..... "Policy interpretation and implementation" indicates: 2. Residents are evaluated for pain routinely ..... The nurse will document on the MAR with the appropriate response. If the answer is yes "interventions will be implemented accordingly." 10. Resident will be re-evaluated within 30-60 minutes after the medication is administered to determine effectiveness of the treatment. Review of R97's Minimum Data Set (MDS) assessment dated 5/1/12 indicated R97 was severely impaired cognitively. R97 was admitted to the facility with a history of dementia, Alzheimer's disease, coronary artery disease, osteoporosis and expressive language disorder. A care plan dated 4/9/12 for chronic, acute and breakthrough pain documented that the resident would demonstrate relief or reduction in pain intensity within 30 minutes after receiving interventions. Approaches included: Monitoring and reporting signs and symptoms of pain and worsening of pain. Also, administering and monitoring for effectiveness of routine pain medication and as needed (PRN)pain medication. Review of R97's pain assessment flow sheet for May 2012 documented that the resident had pain during the 3-11 shift on May 6, 23, 25 and 28, 2012 and June 1, 2012. Also on June 2, 2012 on the 7-3 shift. The Medication Administration Record (MAR) indicated R97 received routine pain medication during these shifts but there was no evidence of a pain assessment or reassessment following medication administration which would allow for monitoring of effectiveness and appropriateness of pain management.	F 309	conducted for the past 30 days to ensure that diagnostic testing was done timely. Any issues identified were corrected and the physician was notified. C. The pain management policy and procedure was reviewed. The ordering of diagnostic testing process and the chart check process has been reviewed and revised. All licensed nursing staff were re-educated on the pain management policy and procedure. Licensed staff has been educated on chart checks, transcribing orders and ordering of diagnostic tests. D. An audit will be conducted monthly on pain management	

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F 309	Continued From page 14 Review of the nurse's notes during this time period revealed that there was no documentation of a pain assessment or pain reassessment. During an interview on 7/30/12 between 10:10AM and 10:30 AM with E2 (Director of Nursing) and E3 (Unit Manager) they confirmed that the nurse should assess and document R97's pain every shift on the pain management flow sheet. When a "yes" was indicated by the nurse and routine pain medication is administered, the nurse should document the pain assessment and reassessment in a nurse's note. They also confirmed that the nurse's note was completed at the end of the shift. This practice was also confirmed by interview on 7/30/12 at approximately 11:00 AM with E8 (staff nurse) who stated that it was her practice to document a pain assessment / reassessment for a routine pain medication in a nurse's note at the end of the shift if pain was present during the administration of the routine pain medication. 2. R63 was admitted to the facility with diagnoses that included hypertension, compression fracture of T7, scaroiliitis, congestive heart failure, and gastroesphageal reflux disease. On 5/18/12 at 5:35 AM R63 had blood drawn for laboratory testing. The results of the blood test stated red blood cells 3.49 (normal limits 3.90-6.10), hemoglobin 9.8 (normal limits 11.8-14.8) hematocrit 28.7 (normal limits 35.3-49.1), platelet count 53,000 (normal limits 140,000-440,000). R63 had a physician order dated 5/18/12 for "serum Iron, ferritin, (TIBC) total iron binding	F 309	documentation X 3 months by the QA nurse or designee. A monthly audit will be completed on timely completion of diagnostic testing. All Results will be brought forward and reported at the monthly QA meeting.	

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F 309	Continued From page 15 capacity and stool for occult blood x3" to be done for R63. Review of R63's Medication Administration Record lacked evidence that the facility obtained stools for the occult blood cultures. On 7/27/12 at 12:46 PM E6 (RN unit manager) reviewed all lab results for R63 and confirmed there was no evidence indicating that R63's stools for occult blood were collected and sent to the lab.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy and procedures and interview it was determined that the facility failed to evaluate two residents (R29 and R199) out of 38 sampled residents for their urinary incontinence to ensure the appropriate treatment and services were implemented to restore as much bladder function as possible. Findings include:	F 315	F315 A. R29 no longer resides in the facility. R199 had a voiding diary completed and a toileting program is now in place. B. An audit was conducted on all residents to ensure appropriate bowel and bladder assessments were completed and toileting programs are in place as appropriate.	9/30/12

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F 315	Continued From page 16 The facility's policy and procedure for "Urinary and Bowel Incontinence-Evaluation and Management Policy and Procedure" stated under "Policy Statement It is the policy of this facility to identify, assess, and provide the appropriate treatment and services to achieve or maintain as much normal urinary and bowel functions..." Under procedures the policy stated: "-Upon completion of the Initial Evaluation for Bowel and Bladder, should the bowel or bladder history indicate anything other than continent, a three day, 24 hour voiding and elimination diary will be implemented. -Subsequent to the completion of the three day diary, an analysis of the data collected will be completed using the 3 day bowel and bladder evaluation tool. Trends will be reviewed to determine the appropriateness of a toileting program for bowel or bladder or both. -Upon evaluation of the data collection from the 3 day elimination diary, an individualized toileting program will be implemented, if appropriate." 1. R199 was readmitted to the facility on 5/30/12 with diagnosis including Alzheimer's disease, hypertension, epilepsy and psychosis. The readmission MDS (Minimum Data Set) assessment dated 6/2/12 documented R199 was severely impaired for cognitive decision making; required extensive assistance of two person physical assist for transfer and toilet use, resident was occasionally incontinent of urine and was not on a trial toileting program. Review of the "Nursing Admission Evaluation" dated 5/30/12; indicated R199 was continent of	F 315	C. Bowel/Bladder assessments, voiding diary and toileting policy and procedures were reviewed and revised. Nursing staff will be re-educated on all toileting revisions. D. All admission/re-admissions and residents with a significant change in status will be audited by the QA nurse of designee for toileting intervention as appropriate. Audit results will be reported at the monthly QA meeting X 3 months.	

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F 315	Continued From page 17 her bladder. Review of the "Initial Assessment for Bowel and Bladder Training" dated 5/30/12 documented that R199's bladder history was "continent" (complete control) of her bladder. In addition, a "voiding/defecation diary" was initiated. Although R199's three day diary revealed that R199 had three episodes of incontinence on 5/31/12 at 1 PM, 5 AM, and 6 AM, record review lacked evidence that the facility analyzed the collected data to identify trends and to determine the appropriateness of a toileting program. Subsequently the significant change MDS dated 6/14/12 revealed R199 remained severely impaired for cognitive decision making and required extensive assistance of two person physical assist for transfer and toilet use. In addition R199 had a decline in urinary incontinence to frequently incontinent. An interview on 7/30/12 at approximately 10:30 AM with E3 (Unit Manager) confirmed that the 3-day voiding diary was initiated but that E3 failed to analyze the "3-Day Bowel and Bladder Evaluation" form at the end of the three days. This portion of the assessment is used to assist in determining the appropriateness of a toileting program. The facility failed to accurately assess and reassess the voiding status of the resident and subsequently failed to implement an individualized toileting program to restore as much bladder function as possible.	F 315		

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F 315	Continued From page 18 Further investigation of R199's bladder function revealed improvement and that she is currently continent of bladder function. "CNA Communication Cardex" documented on 7/20/12 R199 is continent of her bladder. "Admission/Readmission Screen" documented on 7/20/12 by E14 (Nursing Supervisor) R199 is continent of her bladder. The 3-day voiding diary initiated on 7/28/12 documented complete bladder continence hourly for the 3 day time period. During an interview with E16 (Hospice Nurse) on 7/30/12 at approximately 2:50 PM, E16 denied R199 having any episodes of incontinence during his shifts. During an interview with E15 (Hospice Nurse) on 8/1/12 at approximately 10:00 AM, E15 stated that R199 is continent of her bladder and denied witnessing any episodes of incontinence. Findings were reviewed with E1 (administrator) and E2 (DON) on 8/1/12 at 2:45 PM. 2. On 4/2/12 R29 was admitted to the facility with diagnoses that included dementia, seizures, atrial fibrillation, epilepsy, and chronic kidney disease. Review of R29's admission MDS dated 4/2/12 documented R29 was not on a toileting program and was occasionally incontinent of urine. R29 required extensive assistance with 2 person assist with toileting. On 4/3/12 an initial assessment was completed for Bowel and Bladder training that indicated R29	F 315		

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F 315	Continued From page 19 was occasionally incontinent of urine. A 3 day voiding diary was completed and evaluated. R29 was put on a toileting program on 4/6/12. On 6/15/12 R29 was hospitalized for an upper GI Bleed. On 6/18/12 R29 returned to the facility. Review of R29's MDS dated 6/25/12 revealed R29 was moderately cognitively impaired, frequently incontinent, required extensive assistance with one person to physically assist with toileting, and was not on a toileting program. R29's readmission assessment indicated that R29 required a Bladder and Bowel Evaluation. Review of the Bladder and Bowel Evaluation dated 6/18/12 revealed R29 was incontinent and a voiding diary should have been initiated. Review of the CNA communication Cardex revealed R29 was not on a toileting program for the CNAs to follow. Review of R29's clinical record revealed a voiding diary was not initiated and R29 was not put on a toileting program to help promote bladder function. Interview with E12 (CNA) on 7/30/12 at 12:20 PM revealed she toileted R29 every 2 hours and when she rang the call bell and asked to go to the bathroom. Review of the CNAs' continence documentation for R29 for June and July 2012 revealed R29's continence had improved. Review of R29's clinical record with E6 (RN Unit manager) on 7/30/12 at 12:30 PM confirmed R29	F 315		

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F 315	Continued From page 20 should have had a 3 day voiding diary completed and evaluated. E6 continued to state that R29 she should have been put on an individualized toileting program to improve her bladder function. E3 continued to state that R29's continence has improved as her health has improved over the last couple of weeks. R29 was discharged to home on 7/31/12.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	F329 A. R76 had a medication review completed and all medications have diagnosis and targeted behaviors and side effects monitored. R160 had a medication review completed and all medications have diagnosis and targeted behaviors and side monitored B. An initial audit was conducted on 8/13/12 and 8/14/12 by the licensed pharmacists on all residents receiving psychoactive medications (excluding anti-depressants) to ensure residents are appropriately	9/30/12

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F 329	Continued From page 21 by: Based on record review and interview, it was determined that for two (R76 and R160) out of 38 sampled residents, the facility failed to have the resident's drug regimen free from unnecessary drugs including without adequate indication for use and/or without adequate monitoring. R76 had an ordered and administered clonazepam (benzodiazepine) without adequate indication. In addition, the facility failed to ensure adequate monitoring for R76 and R160. Findings include: Review of the facility's guideline entitled "Psychoactive Medication Monthly Flow Record (Also known as the BMF-Behavior Modification Record" indicated: - "When a resident is started on a new antipsychotic/antianxiety/hypnotic drug a new BMF is to be initiated. - Behaviors are assessed and documented on each shift as well as documentation of interventions and outcomes. - Document yes or no if side effects are observed. If side effect(s) observed document in nurses notes." 1a. Review of R76's physician's order dated 6/5/12 revealed an order for clonzepam 0.25 mg. (milligrams) by mouth every 12 hours without an indication or a diagnosis. Review of the June 2012 Medication Administration Record (MAR) and July 2012 MAR revealed that R76 was administered the clonazepam as ordered. An interview with E3 (Unit Manager) on 7/27/12 at approximately 11 AM confirmed the absence of a diagnosis or an indication. A follow-up interview with E3 on 7/27/12 at approximately 3 PM revealed the diagnoses of peripheral neuropathy	F 329	monitored for targeted behaviors, side effects, inadequate diagnosis and appropriate interventions, including non-pharmacological interventions as appropriate. C. BMF was reviewed and revised. Policy and Procedure was developed for reducing or eliminating antipsychotics for residents with behavioral symptoms, side effects and targeted behaviors. Licensed staff and Social Services received education on completion of revised BMF and policy and procedure of reducing or eliminating antipsychotics for residents with behavioral symptoms.	

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F 329	Continued From page 22 and anxiety were obtained from R76's attending physician for the use of clonzepam. 1b. Review of R76's July 2012 Physician's Order Sheet (POS) revealed that R76 was prescribed routine doses of clonazepam 0.25 mg. by mouth every 12 hours as well as Seroquel (anti-psychotic medication) 37.5 mg. by mouth every morning and Seroquel 50 mg. by mouth every night for paranoia and delusions. In addtion, Ativan (benzodiazepine) 0.5 mg. by mouth as needed every 4 hours for anxiety. Review of the three flowsheets (BMFs) revealed the following: 1st BMF: Targeted behaviors for use of the clonazepam incorrectly included delusions, paranoia, and disruptive behavior. These behaviors were not observed during this period of time. The facility failed to consistently have evidence that the staff assessed the presence or the absence of a side effect for the use of the routine medication clonzepam. 2st BMF: Targeted behavior for the use of routine Seroquel included paranoia and talking to others not there. These behaviors were not observed during this period of time. The facility failed to consistently have evidence that the staff assessed the presence or the absence of a side effect for the use of the routine medication Seroquel. 3rd BMF: Targeted behavior for the as needed Ativan was documented as "disruptive behavior." This behavior was not observed.	F 329	D. Audit on residents receiving psychoactive drugs and completion of BMF, targeted behaviors and side effects is conducted monthly, ongoing, by licensed pharmacists and reported by the QA/QI Nurse at the monthly QA/QI meeting.	

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F 329	Continued From page 23 Interviews with E4 (Director of Social Services) and E2 (Director of Nursing) were conducted on 8/1/12 at approximately 10 AM. E4 verbalized that R76 displayed her anxious state by crying and that this would be one of R76's targeted behavior symptoms and an indication for possible use of the Ativan. E2 confirmed that the above BMFs for clonazepam and Seroquel lacked evidence that the staff consistently assessed the presence or absence of a side effects of these medications. In addition, the anxious state as evidenced by R76 crying was the targeted behavior and not being assessed for. 2. Review of R160's July 2012 POS revealed that R160 was prescribed routine doses of clonazepam 0.5 mg. by mouth twice a day and Seroquel 25 mg. twice a day for diagnosis of psychosis. In addition, Ativan 0.5 mg. by mouth as needed every 6 hours for anxiety. Review of R160's two BMFs for July 2012 revealed the following: 1st BMF: Targeted behaviors for use of the clonazepam (with an indication of psychosis) was documented as disruptive behavior. These behaviors were not observed during this period of time. The facility failed to consistently have evidence that the staff assessed for the presence or the absence of a side effect for the use of the routine medication clonzepam. 2nd BMF: Targeted behavior for the use of routine Seroquel (for indication of psychosis) was not identified, although the staff consistently documented that they did not observe a behavior. In addition, the facility failed to consistently have evidence that the staff assessed for the presence	F 329		

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F 329	Continued From page 24 or the absence of a side effect for the use of the routine medication Seroquel. Review of the July 2012 MAR revealed that R160 was administered 11 doses of Ativan 0.5 mg. by mouth. On the back of the MAR, out of the 11 doses administered, nine doses were documented as given due to increased anxiety and it was effective. Record review lacked evidence the reason for the two additional doses of the Ativan. Lastly, record review lacked evidence that the facility monitored the presence or absence of side effect of the Ativan administered. An interview with E2 on 8/1/12 at approximately 10 AM confirmed the above findings related to R160. In addition, E2 confirmed that there was no evidence for the indication for the additional two doses of Ativan and lastly, the facility failed to assess the presence or absence of side effects of Ativan.	F 329		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F371 A. Undated food items were removed immediately. B. All other common use refrigerators were checked to ensure no undated food items were present. Any undated food items were removed as appropriate.	9/30/12

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F 371	Continued From page 25 Based on observation of the station 1 nourishment room on 7/31/12, it was determined that the facility failed to date food items stored in a common-use refrigerator. Findings include: 1. The GE-brand refrigerator that contained food for R41 and an opened soda bottle for R185, had no date indicating when they were placed in the refrigerator nor when the items should be thrown away.	F 371	C. A daily check off list will be implemented and completed by night staff nurse to ensure all common refrigerators are free of undated food items. Any concerns will be addressed immediately. D. An audit of the check list will be completed by the QA nurse or designee monthly X 3 months. Results will be brought forth for review at the monthly QA meeting.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of	F 425	F425 A. R160's medications were reviewed and currently receiving medications as ordered with supporting documentation. R250 and R150's expired	9/30/12

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F 425	Continued From page 26 facility documentation it was determined that for three, (R160, R250 and R150), out of 38 residents sampled, the facility failed to ensure that the pharmaceutical services provided included the accurate dispensing and administration of Ativan on an as needed basis and that medication was not expired before delivery to the facility. Findings include: 1. Review of R160's July 2012 Medication Administration Record (MAR) revealed that R160 was administered 11 doses of Ativan 0.5 mg. by mouth on a as needed basis. On the back of the MAR, nine administrations were documented as given due to increased anxiety and that the interventions were effective. Review of the "Controlled Drug Administration Record" for the Ativan 0.5 mg. revealed that 15 doses was obtained for the same period of time. Further record review lacked evidence whether the four additional doses were administered to R160. An interview with E2 (Director of Nursing) on 7/30/12 at approximately 11 AM confirmed the above findings. 2. On 8/1/12 at approximately 2:45 PM, the unit 3 medication cart had hydroxyzine 50 mg tablets for R204. The facility received 30 tablets from the pharmacy on 5/30/12 and there was an expiration date on the back of the packaging of 3/31/12. The physicians order was for 50 mg, 1 tablet by mouth to be administered every evening at bedtime. Of the 30 tablets received from the	F 425	medications were removed and is now receiving in date medication. B. An audit was conducted on residents receiving PRN medication to ensure administration and documentation is consistent. An immediate audit was completed by pharmacy to ensure all medications dispensed are current. Any issues identified were corrected immediately. C. The process for expired medication was revised. The licensed staff was reeducated on the 5 rights of medication administration including a focus of medications with expiration dates.	

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F 425	Continued From page 27 pharmacy 26 were administered to the resident and 4 tablets remained. E8, staff nurse confirmed during an interview on 8/1/12 at approximately 2:45 PM that the hydroxyzine had a printed expiration date of 3/31/12. A phone interview with E17 (CEO, Pharm Company) was conducted on 8/2/12 at approximately 9:45 AM. E17 provided a faxed copy of the pharmacy log which confirmed that the hydroxyzine that was delivered to the facility had an expiration date of 3/31/12. 3. On 8/1/12 at approximately 2:45 PM, the unit 3 medication cart had hydroxyzine 25 mg tablets for R150. The hydroxyzine was received from the pharmacy on 5/24/12 and expired on 3/31/12. The physician's order was for 25mg / half of a tablet by mouth every 6 hours as needed for itching. 30 half- tablets were received from the pharmacy and of the 30 half-tablets received, 27 were administered to the resident and 3 remained. E8 (staff nurse) confirmed during an interview on 8/1/12 at approximately 2:45 PM that the hydroxyzine had a printed expiration date of 3/31/12. A phone interview with E17 (CEO, Pharm Script) was conducted on 8/2/12 at approximately 9:45 AM. E17 provided a faxed copy of the pharmacy log which confirmed that the hydroxyzine that was delivered to the facility had an expiration date of 3/31/12.	F 425	D. The pharmacy is conducting an on-going monthly audit of medications house wide. Results will be reported at the monthly QA meeting by the pharmacy consultant or designee.	

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F 425	Continued From page 28 Information above reviewed with E1 (Administrator) and E2 on 8/1/12 at approximately 2:45 PM.	F 425	F428 A. R76 had a medication review completed and all medications have diagnosis and targeted behaviors and side effects monitored. R160 had a medication review completed and all medications have diagnosis and targeted behaviors and side monitored B. An initial audit was conducted on 8/13/12 and 8/14/12 by the licensed pharmacists on all residents receiving psychoactive medications (excluding anti-depressants) to ensure residents are appropriately monitored for targeted behaviors, side effects, inadequate diagnosis and	9/30/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to identify and report irregularities during the monthly Medication Regimen Review (MRR) for two (R76 and R160) sampled residents. Findings include: 1. Cross refer F329, example #1a and #1b. Review of July 2012 revealed clonazepam 0.25 mg. (milligram) by mouth every 12 hours lacked evidence of an indication or a diagnosis. An interview with E3 (unit manager) on 7/27/12 at 3 PM revealed diagnoses were obtained from R76's attending physician upon surveyor's inquiry on 7/27/12 and diagnosis included peripheral neuropathy and anxiety. Review of R76's MRR dated 7/18/12 documented "NPP" or "No Potential Problem" although there was lack of an indication or a diagnosis for the use of	F 428		

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F 428	Continued From page 29 clonazepam. In addition, the lack consistent assessment of the presence or the absence of a side effects for the use of clonzepam or the Seroquel. 2. Cross refer F329, example #2. Review of R160's MRR dated 7/18/12 lacked evidence that the pharmacist identified the lack of consistent assessment of the presence or the absence of a side effects for the use of clonazepam or the Seroquel. In addition, the MRR failed to consistently identify the indication for the use of the Ativan on a as needed basis. An interview with E10 (pharmacy consultant) on 7/31/12 at approximately 2:30 PM confirmed for residents receiving psychoactive medications including clonazepam, Seroquel, and Ativan, targeted behavior are identified, monitored as well as an assessment to determine the presence or absence of any side effect.	F 428	appropriate interventions, including non-pharmacological interventions as appropriate. C. BMF was reviewed and revised. Policy and Procedure was developed for reducing or eliminating antipsychotics for residents with behavioral symptoms, side effects and targeted behaviors. Licensed staff and Social Services received education on completion of revised BMF and policy and procedure of reducing or eliminating antipsychotics for residents with behavioral symptoms. D. Audit on residents receiving psychoactive drugs and completion of BMF, targeted behaviors and side effects is conducted monthly, ongoing, by licensed pharmacists and reported by the QA/QI Nurse at the monthly QA/QI meeting.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		

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F 431	Continued From page 30 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations in the medication storage areas on 07/31/12 and 08/01/12, it was determined that the facility failed to properly store and label medications. Findings include: 1. On 8/1/12 at approximately 3:00 PM in the medication room of unit 3, one box of Mucinex DM which is part of the house stock had an expiration date of June 2012. Two heparin flush syringes that belonged to a discharged resident had an expiration date of September 2011. 2. On 7/31/12, station 3 was observed to have a locked tackle box containing controlled medication that was not in a permanently affixed	F 431	F431 A. All expired medications has been destroyed and replaced with in date medications and all undated medications have been removed and replaced. A secured locked box has been installed on all 4 units and permanently affixed to the refrigerator. B. An audit was conducted by the pharmacy on all medications to ensure any expired medication, dating of medications and inappropriate labeling of medications was accurate. Any issues identified were corrected.	9/30/12

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F 431	Continued From page 31 compartment. 3. On 8/1/12, station 2 was found to have 10ml of Lorazepam at 2 mg/ml in a bottle locked in a tackle box in the refrigerator of the medication refrigerator. This medication was not in a permanently affixed compartment. 4. On 8/1/12, station 4 cart #1 had two opened bottle of eye drops: Alphagan and Systane with no dates. This cart also had a Novolog insulin bottle with the date of 8/11/10 on the bottle and a bottle of antacid tablets that was expired on 6/2012. Senior tabs (house stock) expired on 4/2012 and Magnesium tabs (house stock) that expired on 5/2012 were found in the medication storage room. The storage room also had Vitamin K 10mg/ml vials, 2 of which expired on 4/1/12, and 2 of which expired on 5/1/12.	F 431	C. The process for expired medication was revised. The licensed staff was reeducated on the 5 rights of medication administration including a focus of medications with expiration dates and appropriate dating of medications. D. The pharmacy is conducting an on-going monthly audit of medications house wide. Results will be reported at the monthly QA meeting by the pharmacy consultant or designee.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehab and Health Center **DATE SURVEY COMPLETED:** August 1, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced, bi-annual survey and complaint visit was conducted at this facility from July 24, 2012 through August 1, 2012. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and seventy-five (175). The survey sample totaled thirty-eight (38) residents.	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 09/30/12.
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	9/30/12
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	A. R160 has not experienced any falls requiring neurological check since 07/07/12 and R160 has not had any incidents requiring a state report. B. An audit was performed on all incident/accident reports within the past 30 days post survey exit date of 08/01/12. Any reportable incidents identified was reported to the state agency. C. The incident/accident report form was reviewed and revised as indicated. Nursing staff was re-educated on the Reportable Incident Guidelines as indicated by the state agency.

Provider's Signature N. Pa Title Administrator Date 8/21/12

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	Cross refer to the CMS report date completed 8/1/12, F225, F241, F246, F253, F272, F279, F280, F309, F315, F329, F371, F425, F428, F431.	
3201.9.0	**Records and Reports**	
3201.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **This requirement is not met as evidenced by:** Based on record review and review of facility documentation it was determined that for one (R160) out of 38 sampled residents the facility failed to report a fall that required neurological assessment. Findings include: Review of nurse's notes and the facility's incident/accident report revealed that on 7/7/12 at 8:15 PM R160 was found sitting on the floor next to her bed. The fall was not witnessed and neurological checks were initiated.	D. Incident/accident reports are reviewed daily at morning meeting to determine reporting appropriateness to the state agency. Incident/Accident report Audits are conducted monthly X 3 months by the QA nurse or designee and results are reviewed at the monthly QA meeting.